



PLAN A PEDIATRIC QUARTERLY PAYMENT AGREEMENT

This agreement is between _____ the parent/guardian of the primary participant _____, and Jessica Davis, M.D., the physician. This agreement is for access to outpatient primary care services provided at Meliora Family Medicine PLLC.

1. I, _____, will pay the **initial one-time registration fee of \$100**, plus a total of **\$120 (under 2 years old) or \$240 (over 2)** per year, divided into **quarterly payments of \$30 or \$60** per quarter for access beginning ___/___/___ and ending ___/___/___ for the above primary participant. **For children under 2, both illness and wellness visits are billed at a rate of \$120 per hour. For children 2 and up, the annual wellness visit is included in the membership fee.**

Prorated agreement terms: _____

2. Quarterly payments are **due by the first day** of each quarter, for access during that coming quarter. **(Quarters begin January 1, April 1, July 1. and October 1 of each year)**. If the full quarterly payment is not received in the office by the first day of the quarter and no written notification for opting out of the program is received, a bill will be mailed to the participant, and a minimum of \$10 billing fee will be assessed for each bill. The participant will not receive notification beyond this document prior to the bill and the \$10 billing fee.
3. **If payment in full is not received by the 15th of the first month of each quarter, emergency medical care only will be provided through the end of the month and the physician-patient relationship will be officially terminated at the end of that month. Any outstanding balance will be turned over to a collection agency at that time. Initials: _____ Date: _____**
4. Additional charges apply for vaccinations and certain procedures. The fee schedule is subject to change at any time, but will be available prior to any visit for review. You may also check the website for current fees. Do not hesitate to ask for cost information prior to any visit or procedure.
5. A receipt at the end of each visit can be provided for the participant, who then has the option to submit this information to a third party payer (with the exception of Medicare). The physician does not contract with any outside payers and does not guarantee any amount of reimbursement by these systems.
6. This agreement can be ended for any reason by either party with 30 days written notice. Re-entry into the practice requires a \$100 re-entry fee.

I understand and agree to the above terms.

Signature

Date

Office Use Only:

Amount Received: _____ Method: _____ Date: _____ MD Initials: _____



PLAN A PEDIATRIC ANNUAL PAYMENT AGREEMENT

This agreement is between _____ the primary participant, and Jessica Davis, M.D., the physician. This agreement is for access to outpatient primary care services provided at Meliora Family Medicine PLLC.

1. I, _____, will pay the **initial one-time registration fee of \$100**, plus a total of **\$120 (under 2 years old) or \$240 (over 2)** per year for access beginning ___/___/___ and ending ___/___/___ for the above primary participant and the following individuals. **For children under 2, both illness and wellness visits are billed at a rate of \$120 per hour. For children 2 and up, the recommended annual wellness visit is included in the membership fee, other visits are \$120 per hour.**

Prorated agreement terms: _____

2. This agreement can be ended for any reason by either party with 30 days written notice. If the annual examination has not been performed, any unused portion of the access fee will be refunded for any remaining *full months* of access not used. For patients over 2 years old, if the participant has utilized the annual examination option during the one year period designated above, the participant will be refunded for any remaining full months of access not utilized *up to a maximum of one half the annual fee noted above*. Re-entry into the practice requires a \$100 re-entry fee.
3. Full payment for services provided is due at the time of service. Any unpaid balance will be subject to a billing fee (minimum of \$10).
4. The annual wellness exam needs to take place in the time period designated above.
5. As of January 1, 2010, the hourly rate for visits is \$120 per hour. Additional charges apply for vaccinations and certain procedures. The fee schedule is subject to change at any time, but will be available prior to any visit for review. You may also check the website for current fees. Do not hesitate to ask for cost information prior to any visit or procedure.
6. A receipt at the end of each visit can be provided for the participant, who then has the option to submit this information to a third party payer (with the exception of Medicare). The physician does not contract with any outside payers and does not guarantee any amount of reimbursement by these systems.

I understand and agree to the above terms.

Signature

Office Use Only:

Amount Received: _____ Method: _____ Date: _____ MD Initials: _____